UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF OKLAHOMA

DEBORAH YOUNG, as Special Administrator of the Estate of Gwendolyn Young, deceased, PLAINTIFF, vs. CORRECTIONAL HEALTHCARE COMPANIES, INC., DEFENDANT.	Case No. 13-CV-315-IDJ-JFJ

TRANSCRIPT OF JURY TRIAL PROCEEDINGS
VOLUME I
BEFORE THE HONORABLE IAIN D. JOHNSTON
UNITED STATES DISTRICT JUDGE
FEBRUARY 13, 2023 P.M. SESSION

A P P E A R A N C E S

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Reported by: Laura Griffin, United States Court Reporter

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(PROCEEDINGS WERE HELD PREVIOUSLY BUT NOT DESIGNATED AS PART OF THIS TRANSCRIPT.)

THE COURT: So if you're paying attention, the next step is what, opening statements. All right. So, again, start with the Plaintiff. If the Defendant wants to make an opening statement, they can, and then we'll go from there and start hearing witnesses.

So, Plaintiff, if you're ready, go ahead.

MR. SMOLEN: Thank you, Your Honor. Your Honor, can we have the TVs moved just so that the jury -- they could see some of the material that we pull up. I know that they --

THE COURT: Sure.

MR. SMOLEN: Thank you. And we need to get it switched over. Thank you. Thank you so much.

Charlie, could you pull up a picture of 1, please.

Gwendolyn Young was born in Texas in 1960. She relocated to Tulsa with her family when she was a baby. She flipped properties around Tulsa for a long time, buying undeveloped land, holding it, later selling it or holding it for her kids. She had three children; Johnny, Angela, and Deborah. They're all here in the courtroom today.

Johnny runs a trucking and logistics company in Texas. Angela is currently enrolled in beauty school. And Deborah has been an ICU nurse, RN, for the last 19 years.

I've been told that Gwendolyn made a really good chicken and noodle and cornbread and I've been told that her favorite snack was sardines and mustard. I never got to meet Gwendolyn Young because she bled to death over a ten-day period of time in the Tulsa County jail. She bled to death between January the 28th of 2013 and February the 8th of 2013.

At the time of her death, nurses mocked her and called her a faker.

Charlie, would you go ahead and show the jury slide 2, please.

You won't have to take my word for it because the documentation in this case is extensive about the last ten days of Gwendolyn's life. According to official documentation provided by the Tulsa County Sheriff's Office, on the morning of her death, at 8:05 a.m., Young appeared incoherent, but the nurse repeatedly stated that she was faking her actions.

Another employee at the Tulsa County Sheriff's Office, a gentleman by the name of Aaron Wade Sherman, documented almost contemporaneously with her death that Nurse White made the comment that she's faking an injury and trying to get attention.

These nurses worked for a company called CHC. CHC was the contracted jail medical provider in the Tulsa County jail during 2013 when Ms. Young was housed there. The nurses that were tending to Ms. Young were participating in what the

evidence will show is a pattern and culture that existed within CHC to disregard inmate's complaints, to assume inmates were fakers, to deny inmates of emergent medical needs when they desperately needed help.

About ten months before Gwendolyn died in the jail, CHC, through their CMO -- that's a certified medical officer. It's like a CEO for a medical company, it's that high of a level of position. A gentleman by the name of Raymond Herr. Mr. Herr was required to write a letter to the Tulsa County Sheriff's Office, specifically an individual by the name of Brian Edwards. Brian Edwards was the undersheriff of Tulsa County Sheriff's Office at that time. He was the number two guy in charge of the entire sheriff's office.

And on March the 23rd of 2012, Raymond Herr, on behalf of CHC, a company that has more than 550 contractual facilities and on average sees about 300 patients -- 300,000 patients annually, Mr. Herr wrote a letter on behalf of this company and he promised the undersheriff several different things.

He promised the undersheriff in March 23rd of 2013 that CHC would immediately fix the broken sick call system.

Charlie, you can take this down if you will.

He promised the Tulsa County undersheriff that from here on out, I promise CHC medical providers and physicians will conduct face-to-face evaluations for every patient admitted to the infirmary in the jail.

He promised that every inmate who had been housed in the special housing unit would also receive a face-to-face, full evaluation pertaining to their medical health.

Third, Raymond Herr, on behalf of the defendant, CHC, promised unequivocally that he would implement immediately, the day he makes the written promise, an immediate transfer criteria for an inmate who has medical conditions that the jail cannot handle their medical condition so they had to be emergently sent to the nearest emergency room hospital.

Fourth, Raymond Herr, as the medical officer for CHC, promised Tulsa County and the Tulsa County undersheriff that every single infirmary patient's charts would be looked at on a daily basis, that they would be collaboratively reviewed with the physician, the RN assigned to the infirmary, and any other nurse that was assigned to the care of the patient.

Fifth, Raymond Herr and CHC promised the Tulsa County Sheriff's Office that no later than May 30th of 2012 they would implement a protocol that would deal with and specifically address repetitive medical complaints made by patients at the Tulsa County Jail.

And lastly, Raymond Herr, on behalf of CHC, promised and guaranteed that the medical director who was onsite at the Tulsa County Jail, an individual by the name of Dr. Andy Adusei, would no longer be allowed to work within that facility and that he would be terminated no later than May the

31st of 2012.

As I mentioned, one of the promises that was made on March the 23rd of 2012 was explicitly clear. It was that we're going to implement a criteria going forward that every single inmate who presents to the medical staff with certain conditions would be immediately sent to the hospital. Because it was clear by this point, based on the deaths that had occurred in the facility, that they were not capable of caring for patients that fit this category.

And in a half-page document, Raymond Herr, on behalf of CHC, promised Tulsa County nine very specific things as it pertained to immediate transfer for a patient to a hospital outside of the Tulsa County Jail.

Number one, if any inmate presents at any time with a systolic blood pressure of less than 100, they would be sent out emergently and immediately. Simple. Even a lay person could follow it.

Number two, he promised that if any patient presents with a pulse greater than 120 and they have signs of illness, they will be emergently sent to the hospital immediately.

He promised that any patient that had a pulse ox of less than 88 percent would be seen and sent to a hospital emergently.

Any patient with a GI bleed, any patient with chest pain that's ischemic in nature, any patient that had chest pain associated with shortness of breath, any inmate with prolonged

seizure, delirium that was felt to be led by nature, or severe abdominal pain of an unknown cause, all of those patients would be sent emergently to the hospital immediately.

CHC promised that any deviation from this immediate transfer plan would require contemporaneous, written authorization by the chief medical officer, that he would be required at that very moment to override this plan.

This case is critical. What's really important in understanding the promise that was made on March the 23rd, 2012, was what had happened prior to that promise being made and why it was being made to the person it was being made to, the undersheriff.

There were five primary reasons that CHC and Raymond Herr promised the Tulsa County Sheriff's Office in 2012 these very specific things. The first reason this promise was made in 2012 was because that in 2010 and 2009 there were a rash of deaths in the Tulsa County Jail and the Tulsa County Sheriff's Office's risk manager, a gentleman by the name of Josh Turley, and the Tulsa County DA's Office took note of a very public suit in Oklahoma County where CHC was being sued by the Oklahoma County Sheriff's Office.

MR. SNIDER: Objection, Your Honor. Can we take a sidebar?

THE COURT: Sure. Give us a moment.

(THE FOLLOWING WAS HELD AT THE BENCH OUTSIDE THE HEARING

OF THE JURY:)

THE COURT: I'll just remind you that if anybody speaks, be sure you speak into the microphone so the court reporter can hear you.

There's an objection, which is unusual in opening, but go ahead.

MR. SNIDER: Your Honor, plaintiff's counsel just violated motion in limine number 4 with regard to prior lawsuits. The Court said he was not allowed to reference or get into those. He could mention other instances, but not lawsuits.

He just said lawsuits in opening as a basis for this letter in response from Herr. We filed that motion in limine anticipating this, so we object.

MR. SMOLEN: May I respond, Your Honor?

THE COURT: When he's finished.

Are you done?

MR. SNIDER: I'm done.

THE COURT: Okay. Go ahead.

MR. SMOLEN: The motion in limine is specifically pertaining to inmate lawsuits in the Tulsa County Jail against CHC or the county.

This was a lawsuit filed by the County of Oklahoma County against CHC on a breach of contract theory. It was never addressed in the defendant's motion in limine and in fact it

actually makes the evidentiary foundation for the case that this becomes awareness for Tulsa County based on what was happening 100 miles away over in Oklahoma County, but there's certainly nothing in the motion in limine that in any way addresses the lawsuit by Oklahoma County against CHC.

THE COURT: Okay. So the response is the motion in limine 4 related to inmate lawsuits by other inmates, this is my understanding and in the exhibits is that this was an action by a governmental body against CMC.

MR. SMOLEN: Correct.

THE COURT: What's the response?

MR. SNIDER: I believe our motion in limine was addressing suits against CHC, which is what that would have been.

MR. SMOLEN: The motion in limine is --

THE COURT: Don't talk over each other, but go ahead.

MR. SNIDER: The court's order talks about our motion seeking to exclude evidence of other lawsuits, other conduct of any of the defendants. The court said that lawsuits -- at the very end the court said that the -- if the plaintiff seeks to introduce evidence of other litigation, she must first raise the issue with the court and other counsel outside the presence of the jury, explain the relevance of the litigation itself as opposed to the underlying incidents for

conduct.

He should have raised that he was going to use litigation relating to CHC, any litigation. That is the issue.

THE COURT: Hold on a second. I didn't hear that last part.

MR. SNIDER: If he was going to present to the jury or raise to the jury another litigation, he should have raised it to the Court beforehand so we could know what he was going to talk about.

When he stood up and said suits, I didn't know what he was going to talk about, but even still, suits from the county with CHC should be encompassed in this. They're irrelevant to this action. He's already talked about prior litigation. I think we're -- at this point we're severely prejudiced by his statements to the jury.

MR. SMOLEN: In response to that, Your Honor, again, we would stand on the position if the court were to look at the motion in limine, it does -- it certainly does not encompass -- it is our reading of the court's order pertaining to the motion in limine it does not encompass this suit.

But I'm not even going to talk about -- I'm done talking about it.

MR. SNIDER: The problem is you threw a skunk in the jury box.

MR. SMOLEN: I don't think that -- Your Honor, I

really don't believe that that is covered in the motion in limine. When I read the motion in limine, it was about all the other cases that we've had against the Tulsa County Jail pertaining to inadequate medical delivery system in this jail.

I haven't even told the jury anything about what the suit was about in Oklahoma County, it's just -- it's really what precipitates the letter.

MR. SNIDER: Your Honor, any lawsuit, regardless of it being from a patient of CHC's or the Sheriff's Office relating to the provision of healthcare, it would be encompassed by our request here. This is what we sought to have excluded because we want this case to be about the facts and evidence in this case, this issue, not prior litigation, prior lawsuits. It started off on the wrong track.

THE COURT: Yes, we did. Hold on.

This is very difficult for me. Do you have the motion in limine? Because I have a very distinct recollection of what it said, but I want to make sure it's correct. So if y'all are fighting over what the motion in limine requested, somebody hand me that. My recollection to me will be confirmed or disproved by that, because we are definitely starting off on the wrong foot.

Can you -- do you have the motion in limine?

MR. SNIDER: It's document -- 610 was the document.

MS. WINTER: I can pull it up on the computer, Your

Honor. Would that be helpful?

THE COURT: Hold on a second. Document 610.

MR. SMOLEN: It's the first sentence of the motion in limine, first paragraph.

THE COURT: Motion in limine number 4 starts with the sentence which is as broad as it gets, quote, "It would be a violation of the federal rules of evidence to put evidence of other lawsuits and other conduct of any of the defendants into this case." Fed R. Evid. 404(b). Makes sense.

"In this case, the Plaintiff's attorneys have repeatedly attempted to inject information from other irrelevant lawsuits where claims by inmates or employees from the Tulsa County Jail." So, broad, then specific.

The motion then goes on and the second paragraph says, quote, "Allowing plaintiff, plaintiff's counsel or plaintiff's witnesses to introduce evidence of other litigation not limited to inmates, introduced evidence of other litigation, (including but not limited to," again, "including but not limited to separate, unrelated cases filed against these defendants such as -- such as the cases of Elliott Williams, Gwendolyn Young, Gregory Brown, Bridget Revilla, Michael Moritz, Charles Jernegan and Charles Ray) would distract the jury from the issues at hand."

Next paragraph, after citing Fed. R. Evid. 401(b) and 404, also citing federal evidence 403, "Therefore, the only

purpose of attempting to introduce evidence of other lawsuits" -- I'll read that again. "Therefore, the only purpose of attempting to introduce evidence of other lawsuits or claims against any defendant is to inflame the jury on issues which are not related to -- not related or probative to matters in the case."

Why was that limited only to lawsuits by inmates?

MR. SMOLEN: Your Honor, when the Court addressed it in the order, essentially my understanding of the order of holding was that plaintiffs would be not allowed to talk about the other lawsuits that inmates had filed, but that we would be allowed to talk about the other deaths to the extent that the court found they were relevant.

I did not read that motion in limine as a blanket of I can't mention any lawsuits at all. And if that was the intent of the court's order, then I apologize, Your Honor, because we went through this last night, looked through everything, and I just read the motion in limine as those claims that plaintiffs have tried to repeatedly inject into this case, which that's essentially what they argued, but the court's ruling was, if I understood it properly, was that I would be allowed to talk about the deaths to the extent I could establish relevancy, but I would not be able to talk about the fact that there were lawsuits related to those deaths unless I asked for permission.

THE COURT: Did you ask for permission before you got up and said it in front of the jury?

MR. SMOLEN: But this isn't a lawsuit related to any inmate death that I'm talking about.

THE COURT: Your interpretation is absolutely unbelievably wrong, and we have started with a skunk in the jury box.

MR. SMOLEN: I apologize, Your Honor.

THE COURT: Don't do it again.

MR. SMOLEN: I won't.

THE COURT: Sustained.

(THE FOLLOWING PROCEEDINGS WERE HELD IN OPEN COURT WITHIN THE PRESENCE AND HEARING OF THE JURY:)

THE COURT: Ladies and gentlemen of the jury, remember that statements by counsel are not evidence. You're ordered to disregard the statement regarding the lawsuit filed by the county against CHC.

You may continue.

MR. SMOLEN: Thank you, Your Honor.

The second reason that CHC was promising the undersheriff these very specific items was because in 2010 CHC had miserably failed a 2010 medical accreditation audit at the Tulsa County Jail. The audit identified numerous deficiencies in the medical delivery system. You'll hear about the audit. It's referred to as the 2010 NCCHC audit.

The third reason that CHC and Raymond Herr were required to make this promise to the Tulsa County Sheriff's Office in 2012 was because there was an audit in 2011 by the United States Department of Homeland Security. Homeland Security had conducted an audit in the Tulsa County Jail on or around September the 28th of 2011.

During this investigation, Homeland Security officers found numerous issues with CHC's delivery system of medical services at the Tulsa County Jail. Specifically, they found that there was a prevailing attitude of indifference amongst CHC medical staff.

Secondly, Homeland Security officers determined that CHC doctors were using standing orders in violation of state and federal guidelines. They additionally found that nurses were practicing outside their scope of licensure.

Third, they found that CHC nurse staff was undertrained. Fourth, they found that the CHC nurses were not documenting or evaluating patients properly. And, lastly, they determined that CHC was using what they described as a home-grown system of electronic medical records that had failed to take into consideration what had been learned over the last 20 years in correctional healthcare.

The fourth reason these promises were required to be made to the Tulsa County Sheriff's Office was because of the high-profile deaths of Lisa Salgado, Elliott Williams and

Gregory Brown, all who died in the Tulsa Jail in 2011 and 2012. The evidence will show that these deaths were all the result of systemic failures in CHC's medical delivery system.

The fifth reason CHC was required to make these promises on March the 23rd of 2012 was because of a 2011 report conducted by a doctor by the name of Dr. Roemer. His company was called AMS Services. He was a Tulsa County physician.

Dr. Roemer had been brought in by the undersheriff in the Tulsa County Sheriff's Office to conduct an audit as to the medical delivery system under CHC, Tulsa's contractor.

Dr. Roemer confirmed that many of the people that had been housed in the facility were dying needless deaths that were preventable. The deaths included Frankie Thomas on January the 4th of 2010; the death of Damien Tucker on March 12th of 2010; Clinton Labor on March 28th of 2010; Linda Henshaw on June the 18th of 2010; Patrick Gibson on December the 14th of 2010; and Charles Jernegan on September 1st of 2010.

The report further noted that CHC's medical staff were practicing beyond the scope of their licensure and were not utilizing available medical protocols. They were not using appropriate medical guidelines and they were not creating individualized treatment plans for the patients housed at the jail.

The reason Dr. Herr was required to make these promises

to undersheriff Brian Edwards was because Brian Edwards had brought in Dr. Roemer. Brian Edwards had known Dr. Roemer for about 15 years at the time. He understood him to be an expert in the area of medical delivery systems. He trusted his opinion and he trusted his experience in auditing medical systems.

Between 2010 and 2012, Undersheriff Edwards in the Tulsa County Sheriff's Office, risk manager Josh Turley would receive periodic updates regarding Dr. Roemer's findings. Brian Edwards was aware of the NCCHC audit result as well as the 2011 Homeland Security investigations. That's another reason why he was the person who this information was being provided to. Brian Edwards was also in command over the investigation into CHC medical staff involving the death of an inmate by the name of Elliott Williams in October of 2011. And last but not least, this information was required to be given to Undersheriff Edwards because he was second in command of the Tulsa County Sheriff's Office.

The promises made to Undersheriff Edwards are critical to understanding this case. He required that these promises be put on letterhead and memorialized in writing and officially by the highest executive at CHC. He required it because a month later he would be leaving. Brian Edwards would be leaving the Tulsa County Sheriff's Office and taking a new career at the GRDA, the Grand River Dam Authority, as the vice

president.

After Brian Edwards left, roughly 20 days after the explicit promises were made, CHC did nothing to fix the problem. CHC utterly ignored the promises that they had made, and they continued to do what they had done in the past and tried to cover their tracks over inmates who had died needless deaths.

Despite promising Undersheriff Edwards that Dr. Adusei would be terminated on May the 31st of 2012, they instead fired the director of nursing, a lady by the name of Tammy Harrington. Unbeknownst to Undersheriff Edwards, Tammy Harrington had been documenting the systemic failures at the Tulsa County Jail between 2010 and 2012.

Tammy Harrington had not only been documenting the systemic deaths in the facility, but she been reporting all of this information up the chain of command to the highest executive level at CHC corporate.

None of that information had ever been shared to the Tulsa County Sheriff's Office. They didn't know that the director of nursing was documenting these failures as well, contemporaneous to the sheriff's office investigations.

Tammy Harrington, as the director of nursing, specifically reported up the chain of command to CHC that nurses were falsifying medical charts, that nurses were reporting patient vitals when they weren't actually taking

them. She went on to report that she had been specifically requested by CHC's Health Services Administrator, a lady by the name of Chris Rogers, to falsify patient charts for inmates who had been dead and were in severe rigor mortis by the time they had been discovered.

She reported that Dr. Adusei was refusing to see patients unless he said they were, quote, dying or septic. She was reporting that Dr. Adusei was coming to work as the medical director at the Tulsa County Jail with the smell of alcohol on his breath and slurred speech.

She also went on to heavily document the previous medical director, an individual by the name of Phillip Washburn, and his total and utter disregard for patients' -- inmates' needs and inadequate medical delivery system under his control.

CHC, despite their pledge to the Tulsa County Sheriff's Office to terminate Dr. Adusei, the medical director of the facility, chose to terminate the one person who was trying to do the right thing, was trying to fix the problem and was documenting all of it.

Despite its explicit pledge, CHC continued to retain Dr. Adusei for over a year. They continued to retain every nurse that had been identified as falsifying records, falsifying jail incident reports, falsifying statements to investigators that were taking place after the deaths had occurred.

And then in January and February of 2013, CHC breaks the

biggest promise. At least if you're the family of Gwendolyn Young. They broke the promise that they would always transport inmates that had clear emergent medical needs to the hospital, the half page list of nine items that I covered with you earlier in the opening. And I want to show you how their complete disregard for their promise simply killed Gwendolyn Young.

If you would, Charlie, pull up the second cut.

I want to show you a portion of Ms. Young's medical record. You'll see it on the screen in front of you. On January the 28th of 2013 Ms. Young, who has historically high blood pressure, is supposed to be taking medication for high blood pressure.

Her blood pressure drops -- her systolic blood pressure drops blow 100. According to the promise that CHC had made ten months ago, at that very moment, January the 28th of 2013, Ms. Young was required to be sent emergently to the hospital. But no one did anything. They just let her stay in her cell, not helping her at all.

By the time February 4th rolls around --

Charlie, would you go to the next cut, please.

-- Ms. Young's blood pressure had dropped to 80. This was a lady who had a baseline of a blood pressure of about 160. She had been vomiting blood for three days. She had been unable to take her high blood pressure medication and no

one did anything to help her.

Next slide.

On February the 5th, February the 6th, and February the 7th, as Ms. Young laid in her cell continually vomiting everything she could try to eat, unable to take her medication; they did nothing for her. She was in severe pain, continually reporting the stomach pain that she was experiencing to every single medical staff that would listen. And by the morning of February the 8th, the day of her death --

Charlie, next slide if you would, please.

-- at 6:48 in the morning, Ms. Young was banging on the glass of her cell saying she was having difficulty breathing, another criteria that would have required immediate emergency transport.

At 6:40 in the morning, she still could have been saved if they had just followed the promises that they had made to the Tulsa County Sheriff's Office ten months before, but no one did anything for her.

Her respiratory distress was so significant that you'll be able to see it on videotape and you'll be able to watch it during the presentation of evidence in this case. They pushed her on a gurney up against the wall, and they just left her there while she struggled to breathe.

An hour after that --

Charlie, if you would please pull up the next cut.

-- it was reported by TCSO staff --

I want you to go to the larger portion if you would, Charlie, please.

-- the nurses were asking her questions; however, she was not responding to the questions being asked. After evaluating her, the nursing staff made the decision to send her to medical.

At this time Nurse Wallace grabbed ahold of her arms and started to drag her across the floor of the cell. Sergeant Henshaw at the same time said, do not drag her, place her on the gurney. The nurses were dragging Ms. Young across the floor of the cell because her blood pressure had dropped so low because of her internal bleeding that she was unable to walk without assistance.

Charlie, would you use the next cut, please.

Around 10:00 that morning Sergeant Darby, based on what he had been told by the CHC medical staff, said to Ms. Young, "I'm in charge and the medical staff stated to me that you are not going to the hospital."

You see, Ms. Young knew she was in dire need of help. She was begging to go to the hospital. And no one would send her. So she laid there for the next hour and she died alone in a dark cell without her kids, without her 14 grandkids, without her five great-grandchildren. No one did anything to

help her.

The evidence in this case is overwhelming and it's undeniable. CHC had a corporate culture of ignoring inmates with emergent, serious medical needs. CHC's culture was known, it had been known for years. It was pervasive. It was documented. It had been identified to the highest levels of CHC corporate staff. But they did nothing to fix it. They just continued to cover it up, encourage nursing staff to falsify vital signs despite inmates dying tragic and imminently preventable deaths.

As a result of this indifference, Deborah Young is here representing her mother's estate. Her brother and sister voted for her, because of her history as an ICU nurse, to be a voice of her mother.

After I show you all the evidence I just talked to you about, and that's just the tip of the iceberg, you'll be asked to render a decision in this case. This family has waited ten years to get this case to trial and you people will help get it over the finish line. So I just want to thank you for your time.

THE COURT: Thank you, Counsel.

Opening statement from Defense?

MR. SNIDER: Yes, Your Honor. May we address something at sidebar quickly?

THE COURT: Sure.

(THE FOLLOWING WAS HELD AT THE BENCH OUTSIDE THE HEARING OF THE JURY:)

MR. SNIDER: Your Honor, I couldn't help but notice that throughout the course of Mr. Smolen's opening statements he was getting emotional to the point of what appeared to be to me almost crying.

MR. SMOLEN: I was not.

THE COURT: Stop, stop. I've said this many times don't interrupt.

Go ahead and finish.

MR. SNIDER: To the point of crying in front of the jury. Emotional pleas like that are known to be cause for a mistrial. In this instance I think between Mr. Smolen crying, his client crying in front of the jury, in addition to him violating motion in limine number 4, I have to move for a mistrial.

THE COURT: Go ahead, Mr. Smolen.

MR. SMOLEN: Your Honor, as the Court is aware I've worked on a number of these cases over my career. This is the last death in the Tulsa County Jail during this timeframe that I've worked on. I can't help the fact that I'm an emotional human being.

I'm trying to do my absolute best to not, but I'm certainly not up at the stand bawling or making some kind of emotional plea to this jury in an opening, but I would do my

very best. Again you won't see any kind of teary eyes until maybe the closing in this case. But I can't help the fact that somebody in my view of the world was neglected to the point that she just suffered a totally preventable death. Her kids are crying, her family is here, it's upsetting.

THE COURT: Go ahead.

MR. SNIDER: Your Honor, I understand it may be emotional for the family, but it's the responsibility and the professional duty of the lawyers in this case to conduct themselves in a way that they're not garnering sympathy from the jury.

If he prevails at this trial, it needs to be based off the evidence and testimony, not the emotions the jury may feel from Mr. Smolen, and what we saw today was just that. That, on top of the violation of motion in limine number 4 I think is enough for a mistrial to be granted.

And I've seen sanctions granted for lawyers crying during their opening or closing statements before, too, and that may be appropriate as well.

THE COURT: Okay. Okay. There's a comment about Ms. Young crying. I'm not going to hold anything against a daughter for crying when her mother's death is being discussed, especially in the manner that it was discussed. So any crying by Ms. Deborah Young, that's -- I'm not going to take any action on that.

Look, it's emotional, but, counsel, you've got to be professional. It's emotional stuff.

MR. SMOLEN: It won't happen again, Your Honor.

THE COURT: We have a dead human being with a lot of family who is here. They're upset, they're outside -- mostly outside the view, they're way off to the side of the court. I hadn't seen a juror look over to the family yet so far. I've been eyeing both the family and the jury to see if that was occurring and I did not see any jurors looking for the family members. And they can obviously see Ms. Deborah Young because she's sitting right in front of them.

But, Mr. Smolen, if you can't control your emotions, you let me know and we'll take a break so you can keep your emotions under control.

As to the combination of the violation of motion in limine number 4 with the emotional actions by Mr. Smolen, it's close. We've had -- the opening was really cutting a line close to closing argument, but there was no objection on that.

I instructed the jury to disregard the statements regarding the lawsuit filed by the county against CHC, so I think that cured it, in addition to the instructions that I gave them before they heard openings, and in addition to the instructions that they'll hear in closing as statements that are not evidence, and in addition to the instructions I told them to disregard things they should disregard.

So, Mr. Smolen, if you're going to lose control of your emotions, give me notice and we will take a break so that you can regain your emotions, but I fully expect you to continue in control during the remainder of the trial.

MR. SMOLEN: I understand, Your Honor, I apologize. I was doing my very best.

THE COURT: All right. The motion for mistrial will be denied.

Counsel, you've got two warnings already and we haven't done a witness on the stand yet, okay. So let's get this thing done and done right.

(THE FOLLOWING PROCEEDINGS WERE HELD IN OPEN COURT WITHIN THE PRESENCE AND HEARING OF THE JURY:)

THE COURT: All right, ladies and gentlemen of the jury, what is it, 3:42.

Who's the first witness and how long do you think that witness's testimony will be for the plaintiff?

MR. SMOLEN: The first witness that the Plaintiff will call would be Billy McKelvey, and I anticipate it will be several hours of testimony. But, Your Honor, I believe he'll be one of the longer examinations.

THE COURT: Okay. Is there a reasonable breaking point in his testimony that you could anticipate in about 45 minutes?

MR. SMOLEN: Absolutely.

THE COURT: Then we'll get Mr. McKelvey on the witness stand.

MR. SMOLEN: Are they doing their opening or they waive?

MR. SNIDER: We are going to do our opening statements now.

THE COURT: That's fine. That's fine. Okay. Sorry about that, Counsel. Let me know when you're ready.

MR. SNIDER: Good afternoon. My name is Sean Snider. Also at my table is Anthony Winter, Ronald Chapman, and here on behalf of CHC as a corporate representative is Jamie Vaz. Also at our table is Brian Ramsey who is going to be putting up stuff for us occasionally.

I'd like to thank you for your time and service on the jury. What we're doing now is outlining what the evidence will be. It's not the evidence that comes next.

What Mr. Smolen has told you the evidence will be is just his opinion as to what the evidence will be, just like what I'm about to tell you the evidence will be is my opinion as to what the evidence will be in this case.

You heard from Ms. Young's counsel first today and that's how this is going to go. They have the burden of proof in this case, so they get the first word and the last.

There are some parts of this story that both sides are going to agree on and other parts we're going to disagree.

Other parts we're going to disagree to great ends. While we as the defendants don't have the burden of proof in this case, there's one thing that we are going to do, we're going to show you the whole picture, what was really going on. We're going to show you and put on evidence and testimony of what treatment Ms. Young was receiving while at the Tulsa County jail.

While I ask that you pay close attention to the evidence and testimony that the plaintiffs put on in their case in chief, I also ask that you wait and listen to the testimony and see the evidence that we're going to put on and what we're going to show you as well.

Wait until you hear and see all the evidence of how the medical unit was staffed on that day, the staffing levels for the nurses and physicians and nurse practitioners on the day of Ms. Young's death. Wait until you hear how CHC had processes in place to ensure that patients had access to mid-level providers, nurse practitioners, or physicians 24 hours a day, seven days a week.

Wait until you see how CHC and the Tulsa County jail had a system in place to ensure that if a patient was sick, if a patient was ill and needed to be treated at a higher level of care facility, they would be immediately transported to a hospital.

Over the next few days each side will put on evidence and

show what we believe happened in this case. We do agree on some things and others we don't. For instance, both sides agree that when Ms. Young died she was 52 years old and an inmate at the Tulsa County Jail, and that she had a medical history of a prior stroke with right-sided weakness, diabetes, hypertension, hyperlipidemia, high cholesterol, severe chronic back pain and acid reflux or heartburn.

The evidence will be that Ms. Young also suffered from mental health problems and was diagnosed with bipolar disorder and borderline personality disorder. You're going to see that the bipolar and borderline personality disorder often made her agitated and that she would often not want to take her prescribed medications.

The evidence will be that Ms. Young was not new to the jail at the time of her death in February of 2013. At the time of her death she had been incarcerated at the Tulsa County jail since October of 2012. Prior to that incarceration Ms. Young had been incarcerated at the jail from August of 2011 to March of 2012.

The evidence will be that Ms. Young had a well-documented history of knowing how to report her medical concerns to the staff at the Tulsa County jail. For example, you're going to see that Ms. Young had a history of reporting her food upsetting her stomach. She had a history of acid reflux or heartburn requiring medication for relief.

You're going to hear testimony and see evidence that on February 7th, 2013, the day before her death, Ms. Young complained of vomiting blood and not eating for three days. You're going to then see where she was evaluated by a nurse who determined that she had not vomited blood. The evidence will further show that that same nurse checked with the detention staff and their paperwork and confirmed that Ms. Young had been eating those prior three days.

The nurse then instructed Ms. Young to make sure she was getting adequate hydration by drinking at least two liters of fluid a day. You'll see that on the following morning, the morning of the 8th at 6:00 a.m., or around 6:00 a.m., Ms. Young complained of lower back pains, nausea and vomiting.

In response, she was taken to the medical unit in the jail on a gurney where she was seen by and assessed by the nursing staff. Her vital signs were taken and found to be stable and within her normal limits. And were reported -- those vital signs were reported to the on-call nurse practitioner.

The complaints of lower back pain and nausea and vomiting were also communicated during that call to the nurse practitioner. Ibuprofen was given for her lower back pain. And in response to her reports of nausea and vomiting, the nurse practitioner changed Ms. Young's order from Zantac, a prescription for heartburn, to a different type of heartburn

medication, Prilosec.

After receiving her medications and being assessed by the nursing staff in the medical unit, Ms. Young requested to be taken back to her cell. As such, Ms. Young was then escorted back to her cell from the medical unit on a gurney.

Now, Ms. Young was in a cell. She wasn't housed in the medical unit as a medical patient. She was housed in a segregated housing unit at the jail, not because of her health issues, but because of her behavioral issues that she had had. That's important when you listen to the evidence and see the records in this case to consider why she was where she was at, why she was segregated. She wasn't being segregated because of her medical issues; it was for other reasons.

You're going to see that on the morning of February 8th -- I'm sorry, on the morning of February 8th after she had returned back to her cell -- she was escorted back -- the evidence will be that the detention staff continued to round on Ms. Young.

In addition to the detention staff checking on her, the evidence will be that one of the same nurses that had seen her in the medical unit also came back to her cell, a different part of the jail, to check on her hours later.

The evidence will show that during that check Ms. Young did not respond to them calling her name. The nurse and the detention officer opened her cell and checked to see if she

was okay. Upon examination she was found to not be breathing and didn't have a pulse. As a result they called an immediate medical emergency. CPR was initiated immediately. Three additional nurses came to help and assist with trying to resuscitate her.

Dr. Andrew Adusei was also the physician that arrived shortly around that time for his work -- normal schedule. He then came to her unit and began helping out with CPR. EMS was called a short time later to take over CPR and she was ultimately transported to the hospital.

Once at the hospital, Ms. Young was ultimately declared dead. The evidence will be that not a single person, not a single person that saw Ms. Young on February the 8th or February the 7th, observed any signs of head trauma to Ms. Young.

Nobody observed any signs of head trauma to Ms. Young. None of the detention staff, none of the nursing staff, none of the medical staff, none of the EMS team, and not even the physicians at the hospital where she was brought to and ultimately declared dead. In fact, the evidence will be that the hospital physician listed cardiac arrest as her clinic -- as his clinical impression for why she had died.

The evidence will be that no one knew the secret that Ms. Young's body had until the medical examiner performed his autopsy. You're going to see and hear that the medical

examiner also did not note any signs of external trauma to Ms. Young's head. He did, however, upon autopsy find a 100 milliliter clot of blood located in the subdural space which is below the skull in dura mater. Blood in the space that nobody's eyes could possibly see.

You're going to hear that a fatal bleed like Ms. Young had was insidious, extremely difficult for any physician to diagnosis. You're going to hear that a fatal bleed like Ms. Young's is not only challenging to diagnose, it's equally challenging to find and treat in time to save a patient's life. Even when there is a known history of head trauma, which the evidence doesn't have in this case.

Like I said, there are some things we're going to agree on and a lot that we're not. One such thing that we're going to disagree on is whether Ms. Young exhibited any signs or symptoms severe enough to warrant her being transferred to a hospital via ambulance.

The evidence will show that Ms. Young's complaints were vague, nonspecific, and consistent with her prior known health history; chronic back pain, nausea and vomiting. We will show you the actual information that the nurses and the medical providers had when using their clinical judgment at the time of their care of Ms. Young.

For example, you're going to see that her prior history of abdominal and gastrointestinal complaints were being

treated just like the nausea and vomiting she experienced on the 7th and 8th. You're going to see that the evidence of her having reported history of severe, chronic back pain was being treated by the nurse and the medical staff at the jail.

You're going to see that the evidence that the nurses promptly checked Ms. Young's vital signs, which were stable and nonemergent. In addition to that big disagreement we have over whether or not she was exhibiting any obvious signs or symptoms of being in a serious medical condition, we disagree on whether any earlier or different treatment would have saved her life. We disagree as to whether CHC had a policy or practice that was constitutionally inadequate. And we disagree as to whether any of CHC's policies or practice caused Ms. Young's death.

We believe that the evidence will show that CHC's medical system at the Tulsa County jail was constitutionally adequate and that none of its employees -- none of its employees were indifferent to Ms. Young's serious medical needs.

As you listen to the testimony and see the evidence in this case, keep in mind what it is you're here to decide and as the court will instruct, as I mentioned, you will hear their side of the story first and then we get to go. Please pay close attention to both sides of the evidence before coming to any conclusion.

At the conclusion of this case we believe that you're

going to find that on February the 8th, 2013, CHC's policies and practices at the jail were constitutionally adequate, that none of CHC's nursing staff or physician staff were deliberately indifferent to Ms. Young.

Likewise, we believe that you'll find that Ms. Young unfortunately died as a result of a silent, invisible, insidious, subdural hematoma that developed without any specific signs or any reports of head injury. At that point we're going to ask that you return a verdict in our favor. Thank you.

THE COURT: Thank you, Counsel.

All right. Let's start with Mr. McKelvey.

MR. SMOLEN: Your Honor, we would call Mr. McKelvey to the stand.

(WITNESS SWORN.)

THE COURT: Good afternoon, Mr. McKelvey. Mr. McKelvey, have you ever testified in court before?

THE WITNESS: Yes, sir.

THE COURT: So you know to speak slowly, clearly into the microphone, let counsel finish with his questions before you start answering a question. Likewise he's going let you finish with your answer before he launches into another question; okay?

THE WITNESS: Yes, sir.

THE COURT: Thank you.

BILL McKELVEY,

having been called as a witness, after being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SMOLEN:

Q. Good afternoon, Mr. McKelvey. Would you please state your full name for the record.

A. Billy Joe McKelvey, Sr.

Q. Mr. McKelvey, are you currently employed?

A. Yes.

Q. How are you currently employed, sir?

A. I currently own and operate my own construction company.

Q. Okay. And have you ever been employed in law enforcement?

A. Yes.

Q. Okay. And can you tell the jury a little bit about your work history in law enforcement if you would, please.

A. I started in law enforcement on my 21st birthday in 1993. I retired out of law enforcement in September of 2018 for 25 years. During that time I worked patrol, investigations, internal affairs, training, command staff level, SWAT team, assortment of duties like that.

Q. As it pertains to your investigative jobs in law enforcement, were you ever employed to work in jail investigations?

A. Yes.
Q. And was there a name for that? I mean, I know you mentioned IA, but was there a name for jail investigations?
A. Yes.
Q. And what was that, sir?
A. Jail -- JCIU, jail criminal investigative unit.
Q. Okay. Can you tell the jury just briefly as far as what was important, what was the JCIU and what were their responsibilities?
A. JCIU, we did a host of things there, we monitored inmate phone calls, field requests from other law enforcement agencies that might want copies of their phone calls, monitored visitation logs and, you know, provided information to other law enforcement agencies on who may be coming and going within the jail to see certain people.

To work with the mail delivery system inside the jail concerning gang activity, making sure the inmates -- if we had any requests from inmates that they needed to stay away from, to work with classifications unit to make sure that inmates stayed away from other inmates.

We also investigated fights amongst inmates in jail, minor complaints on staff that's in the jail. Just a host of things within the jail.
Q. Okay. Mr. McKelvey, did officers that were assigned to the JCIU, did they have any involvement in any way in

investigating inmate deaths at the Tulsa County jail?
A. Yes.
Q. Can you describe to the jury what involvement a JCIU officer might have as it pertained to a Tulsa County jail death?
A. When a jail death would occur, obviously the criminal investigative unit within the Sheriff's Office called CID, Criminal Investigative Division, would work the actual death of the inmate like the crime scene, et cetera.

And then the jail investigative unit would recover any documents within the jail that pertained to that inmate's death like copies of medical records, inmate visitations, any requests from the inmate that had been sent to any person within the jail like classifications or food or doctor or, you know, the medical unit or for clergy or anything.

We would basically recover all of the information we could on this particular inmate to help the criminal -- the Criminal Investigative Division to figure out what happened.
Q. Okay. Mr. McKelvey, if you would just let the jury know what timeframe of your career in law enforcement that you were working in this JCIU unit?
A. It's been awhile so I'm going to try to remember. I was working in the training division within the jail and then sometime in the middle, I'm going to guess to say 2009 timeframe, May, June, July timeframe, I was transferred from

the training division to the jail investigative division inside the jail.

Q. Okay. And for roughly how long did you serve in that capacity at the Tulsa County Sheriff's Office?

A. I worked there until I was transferred to internal affairs, roughly, July timeframe, August of 2010.

Q. Okay. What was the difference between -- you mentioned you were transferred in July of 2010 from JCIU to internal affairs. What's the difference? If you would, just explain to the jury the difference between those two groups.

A. The jail investigative unit just does simple investigations in the jail, not really complex investigations within the jail, just your -- just a basic level of investigation.

Internal affairs within the Tulsa County Sheriff's Office at that time investigated policy and procedure related complaints on any Tulsa County Sheriff's Office employee.

Q. Okay. Would the internal affairs division and officers assigned to that division also investigate medical staff that were employed within the jail that were employees of CHC?

A. Ask that one more time, please.

Q. Would the internal affairs division of the Tulsa County Sheriff's Office, when they were conducting investigations, ever investigate the actions or inactions of any medical staff employed at the Tulsa County Jail?

A. Yes.
Q. And did you understand that medical staff, during at least your time in the jail, to be employees of CHC?
A. Yes.
Q. Did you yourself have direct involvement as an internal affairs officer working injuries or deaths in the Tulsa County jail?
A. Yes.
Q. Can you tell the jury just briefly, if you recall, what the first investigation that took place as it specifically pertained to jail medical was?
A. When I first went to -- when I first reported to internal affairs, I reported to a gentleman by the name of Robbie Lillard. He was a sergeant. Shortly after reporting to him, there was an incident in the jail where the undersheriff had heard about this, I don't know how the undersheriff had heard about this incident --

MR. CHAPMAN: Your Honor, I'm going to object. If the undersheriff heard about something, it's going to be hearsay if he's not here to talk about it.

THE COURT: Objection, rule, basis, response, reply. No speaking objections.

So what is the objection? Give me a rule.

MR. CHAPMAN: The objection is hearsay, 803, Your Honor. It's an out of court statement.

THE COURT: Well, I think it goes to course of action because that's what he's asking, but what's your response?

MR. SMOLEN: That was my response, that it goes to the course of action as far as what he was doing based on his assignments. It's not also a statement that we're using to --

THE COURT: Not for the truth of the matter asserted.

MR. SMOLEN: Right.

THE COURT: Okay. Ladies and gentlemen, the statement to what is said just goes to show what he did and why he did it, his actions based upon what he heard, not the truth of what was told to him; okay?

Overruled.

MR. SMOLEN: Thank you, Your Honor.

Q. (BY MR. SMOLEN) Mr. McKelvey, you can continue.

A. Robbie Lillard and I went to the jail, evidently this -- this inmate had been brought into the county jail on a public intoxication charge. And within just a few hours he was transported to the hospital because he had a large laceration somewhere on his head, on the front of his head, whether it be the face or the forehead.

The reason I remember it is it was my first investigation in internal affairs and the gentleman was wealthy, and I remember it because we dubbed it a skull cap, we called him

the skull cap man.

He had been involved in an accident, he crashed his car, left the scene of this crash, was walking down the road. Tulsa police was called to the crash, couldn't put the -- couldn't put him -- I believe his last name was Byrd, I can't remember his first -- could not place him in the car and they arrested him for public intoxication and booked him in the jail.

He was in the booking process and was looked at by detention staff and the nurse was processed through the booking process and was sent to a cell within the jail.

On video you could tell there was nothing wrong with him on the video -- the best I can remember, the jail staff and medical looked at the back of his head on the left side and he -- when he -- when he wound up in his cell within a few minutes his celly, the person he was living with or potentially going to be living with in the cell, notified the jailer within that pod that there was a problem with this inmate and somehow somewhere he had fallen and cut his forehead.

Well, he was taken to the hospital due to the fall and the injury to his head and they did a CT and found that he was experiencing a brain bleed. And being that he was at the hospital, he survived.

We called him skull cap because they peeled his skull

back or his scalp back exposing his skull and did whatever, you know, surgery they needed to do. And he never came back to jail. I don't know what happened to him. I know that he survived but I just don't know what happened to him from there.

Q. Okay. And I think you had said to the jury that was your first investigation in IA; is that correct?

A. Yes.

Q. Did you have an opportunity while you were serving in IA to actually investigate any jail deaths?

A. Yes.

Q. Okay. If you would, can you tell the jury what you recall or if you recall what the first jail death was that you investigated?

A. The first jail death that I investigated from an I -- from an internal affairs standpoint was an inmate by the name of Elliott Williams.

Q. And can you tell the jury how you got involved in that investigation while you were assigned to internal affairs?

A. That particular day I don't know why I was at the jail. I was there on another investigation of some sort. I had heard a medical emergency called over the radio. I had heard that an inmate was possibly deceased and so I went to medical just to -- just to walk through because I know I -- I know the Undersheriff Brian Edwards at the time was going to ask me and

so I walked through, seen where this gentleman had died, and I had talked to the chief of the facility Michelle Robinette and at that time Robbie Lillard had been transferred to the jail and he was a captain, administrative captain at the jail and I talked to him and then I left.

Q. Okay. Did you ultimately become the lead investigator on that jail death?

A. Yes.

Q. Okay. So as a result of that investigation were you required to write a report?

A. Yes.

Q. If you would, could you briefly just summarize to the jury what your conclusion was as it pertained to Mr. Williams's death based on what your specific assignment was?

MR. CHAPMAN: Your Honor, objection. The witness is reading a statement and it hasn't been used to refresh his memory.

THE COURT: Okay. I can't see that.

Are you reading from something, sir?

THE WITNESS: No, sir.

MR. CHAPMAN: He brought one with him.

THE COURT: Overruled.

Q. (BY MR. SMOLEN) Mr. McKelvey, let me just ask you this way: Do you recall what the specific assignment was that you had?

A. I recall not a hundred percent specific, no, but I do recall snippets of it.
Q. Did you bring a copy of your investigation with you today?
A. Yes.
Q. Okay. Would it help refresh your memory if you were able to look at your investigative report as it specifically pertains to what the investigation assignment was as it pertained to what you were to do?
A. Yes.
Q. Go ahead and take a look, if you would, at that report, Mr. McKelvey, and see if it refreshes your memory.
A. Yes, sir.
Q. Okay. Can you tell the jury, after you've had your memory refreshed, what your specific investigative assignment was as it pertained to Mr. Williams' death?
A. I was instructed to find out if any Tulsa County employee had violated any policies surrounding his death. I was asked to look at any actions or inactions taken by the medical unit and if there was anything that they did that contributed to it -- contributed to Inmate Williams' death.
Q. When you say the medical unit, did that include the employees of Correctional Healthcare Company?
A. Yes.
Q. Do you recall if you were also asked to determine whether

or not any CHC's employees's actions or inactions had contributed to the death of Mr. Williams?

A. I -- this investigation took place in the latter part of October 2011 and I either interviewed or reviewed audio tapes of interviews by a number of other investigators and my typed report is 80-plus pages long.

Q. Okay.

A. And at that time I had three 3-ring binders full of information, so I can't remember everything.

Q. Take a look at the first page of your report under the investigation assignment and it's number 3 and see if it refreshes your memory.

A. Yes.

Q. Okay. And after you've had your memory refreshed, can you tell the jury what specifically you were assigned in number 3 to do during this investigation?

A. Was there any wilful acts by TCSO employees or Correctional Healthcare Company employees that caused the death.

Q. Can you tell jury -- you said you had three large binders that you ultimately gathered information of pertaining to that death. Can you give the jury just some sense of idea as to what material you were referencing? What you were actually looking at to investigate the death?

A. I -- there was a total of roughly 50-plus-or-minus

interviews conducted. There were hundreds of pages of medical documents, jail reports, pod reports, information that the -- the jailers type into a computer and videotape evidence, reports from other law enforcement agencies that was completed and was given to us concerning this investigation for me to do a -- an overall view of what occurred.

Q. Okay. So we're talking about jail documentation, medical records, videos, all of that stuff?

A. Yes.

Q. Witness interviews, all of those things?

A. Yes.

Q. And after you completed that investigation -- well, let me ask you, how long did it take?

A. If memory serves my correctly, I finished the report early March of 2012.

Q. And were you able to come to any findings based on this extensive investigation that you conducted?

A. Yes.

Q. Okay. And are you able -- I know it's been over ten years, are you able to specifically tell the jury what those findings are?

MR. CHAPMAN: Objection, Your Honor, under 701. This is a lay witness. He's unable to give opinion testimony particularly based on scientific or technical knowledge. He's reviewing medical records where they talk about an employee

whether they --

THE COURT: Did you hear the no speaking objections part?

MR. CHAPMAN: Pardon?

THE COURT: Did you hear the no speaking objections part?

MR. CHAPMAN: Sorry.

THE COURT: So the question was, are you able -- "I know it's been over ten years, are you able to specifically tell the jury what those findings are?"

So can you answer that question?

The question is, do you remember what the findings were as to this investigation and do you remember counsel is asking about the scope and he was focusing on the scope of the investigation relating to conclusions relating to CHC.

Do you recall what your conclusions were as you sit here today?

A. No, be not 100 percent specifically.

THE COURT: Okay. There's the answer.

So overruled. Ask another question.

Q. (BY MR. SMOLEN) Mr. McKelvey, did you memorialize your findings as the lead investigator in the IA unit after your investigation?

A. Yes.

Q. And did you prepare a summary of those findings?

A. Yes.
Q. Do you have a copy of that with you?
A. Yes.
Q. Would that refresh your memory about what your findings were specifically as it pertained to medical staff?
A. Yes.
Q. And if you would, take a minute to look at that document. I don't want you to read from it but look at it and when your memory has been refreshed, I want you to tell the jury what you recall the summary of your findings to be.

MR. CHAPMAN: Objection, Your Honor. This is the 701 objection.

THE COURT: Right now all he's doing is refreshing his recollection. That's all he's doing.

MR. CHAPMAN: Counsel said when you're done --

THE COURT: That's all he's doing.

MR. CHAPMAN: Okay.

THE COURT: When you're done, let counsel know. Thank you.

Q. (BY MR. SMOLEN) And, Mr. McKelvey, have you had a chance to review your summary findings?
A. Yes.
Q. And I'm asking you specifically, I don't want you to make any opinions, I'm asking you specifically to tell the jury what you found factually from the investigation as it

pertained to the medical staff.

MR. CHAPMAN: Your Honor, again this is the 701. He can't give that testimony as to what he found. He would have to give opinion testimony to do that, Your Honor.

THE COURT: Are you going lay the foundation? I don't know why we have to do this, but are you going to lay a foundation that this is a fact? I think you have that this is a report, investigation by a public body which by definition is not hearsay.

MR. SMOLEN: I will be doing that. I just didn't know we were going to do that every time but I'll do that.

THE COURT: Why don't you lay the foundation for that.

MR. SMOLEN: Absolutely.

Q. (BY MR. SMOLEN) Mr. McKelvey, as part of your job as investigator in internal affairs, were you specifically required to draft a report to your superior?

A. Yes.

MR. CHAPMAN: Your Honor, may we approach for a minute?

THE COURT: We'll take a quick break, okay. Thank you.

(THE FOLLOWING PROCEEDINGS WERE HAD IN OPEN COURT, OUT OF THE PRESENCE AND HEARING OF THE JURY:)

THE COURT: All right. What's the issue?

MR. CHAPMAN: The issue with respect to this, is this is not an exhibit, Your Honor.

THE COURT: It's not what?

MR. CHAPMAN: It's not an exhibit. It was never offered, it's not on an exhibit list, it has nothing to do. So laying a foundation to arguably to have it admitted or so that he can talk about it is an end run around our requirement to list exhibits.

THE COURT: Okay. Well, are you offering it as an exhibit?

MR. SMOLEN: No, I'm not offering it as an exhibit.

THE COURT: Okay.

MR. SMOLEN: We're using it to refresh his memory based on what his investigation was.

THE COURT: Okay.

MR. SNIDER: But then you wouldn't qualify. We could use anything. We could use a leaf from outside to refresh somebody's memory to go through qualifying what this is. It's a precursor to having being admitted, that's not what you do.

THE COURT: Well, do you want him to lay a foundation or don't you? You're arguing circles. It's objection 701. It's opinion -- don't interrupt me.

MR. CHAPMAN: I'm not, I'm not.

THE COURT: 701 and then I'm asking whether it's --

is it coming in, are you using it as an investigation?

Answer, yes.

Okay. We can lay the foundation so we can avoid this whole 701 issue, and now you're saying he can't lay the foundation.

So if he's not offering the exhibit, I guess you don't have to lay the foundation, so I don't have to do that, so what's the problem?

MR. CHAPMAN: The problem, Your Honor, is, one, under 701 he can't give opinion testimony.

THE COURT: Yes, he can.

MR. CHAPMAN: I'm sorry?

THE COURT: Did you read 701?

MR. CHAPMAN: Yes, I have, Your Honor, it's based on scientific information. He's giving testimony relating to health care.

THE COURT: We haven't even heard his opinion and he's giving you, what it sounds like, is his opinion as to the investigation as to, if my notes are correct, as to "there were wilful acts caused by CHC that caused the death." Right?

THE WITNESS: Yes, sir.

THE COURT: Okay.

MR. CHAPMAN: My argument is that would be based on scientific knowledge. He's not a medical professional. How can he determine whether or not a nurse or a doctor or

somebody did a wilful act that caused somebody's death.

THE COURT: It's wilfulness; right?

Overruled.

This is going to be a long, long trial. We've got two weeks. All this stuff you're -- you're new to this case. You find a case as you arrive, especially if you arrive the week before. A two-week jury trial in a 2013 case. Okay?

You may have a lot of ideas rummaging around in your brain matter, that's great, but you can't be dropping them on me with the first witness within half an hour of testimony as to a critical document.

That's why we have the final pretrial conference. That's why you're supposed to do this giant order. These are things if you're going to bring them up, there's motions in limine. Why wasn't there a motion in limine on this thing? I assume you took this man's deposition. Did anybody take his deposition?

MR. SMOLEN: Nope.

MS. WINTER: Not in this matter, Your Honor.

THE COURT: Have you taken his deposition in other cases?

MR. WINTER: Yes, Your Honor.

THE COURT: Did it relate to the investigation of Mr. Williams' death?

MR. SNIDER: Yes, Your Honor.

THE COURT: Did you know what his report said? Have you seen his report?

MR. SNIDER: Yes, Your Honor. It's not listed as an exhibit in this case.

THE COURT: But he said he's not offering it.

MR. SMOLEN: Right. I'm not offering it.

THE COURT: What clearly is Mr. Smolen's intent is to get from this witness what, if any, conclusions he drew within the scope of his investigation as to whether there was any wilful acts by CHC that caused the death of Mr. Williams. Right?

MR. SMOLEN: Yes, sir.

THE COURT: Okay. Why isn't that admissible?

MR. CHAPMAN: Is that rhetorical or are you asking me a question?

THE COURT: I'm asking you a question.

MR. CHAPMAN: Because in order to arrive at that conclusion whether something is wilful, he would have to be applying scientific technical knowledge regarding what are the duties and responsibilities of a nurse or a doctor, whether doing this or doing that was within the standard of care or not in the standard of care in order for him to make that determination. He's not a doctor, he's not a nurse, he's not a healthcare provider.

THE COURT: So there's certain medical activities

that are just so blatantly obvious that an average lay person can't say -- come to the conclusion that it's wilful? That if you went to a doctor and you said, doctor, my left eye hurts, and he says, great, let me amputate your right toe?

MR. CHAPMAN: Are you asking me?

THE COURT: Yeah.

MR. CHAPMAN: That could be obvious.

THE COURT: Okay.

MR. CHAPMAN: But that's not what we're getting to here.

THE COURT: You don't even know.

MR. CHAPMAN: Because I'm trying to prevent it from coming out to the jury before we know what the person is going to say. I think I know what he's going to say.

THE COURT: What are you going to tell him?

THE WITNESS: What I found was that Elliott Williams died from a broken neck.

THE COURT: Okay. How did you learn that?

THE WITNESS: I read a document from a medical examiner that says he has a broken neck.

THE COURT: What else do you want from this witness? If that's what his conclusion is and it's based upon reading a document that says the man died from a broken neck, are we going to bring in a doctor that says he died from a broken neck and then have this witness that says, I relied upon a

medical record from a doctor that says he died of a broken neck? Is that what we are going to do?

MR. CHAPMAN: No, Your Honor, but I highly doubt he's on the witness stand to say Mr. Williams died of a broken neck. But maybe that's all he's going to say.

THE COURT: I just asked the man what his testimony would be, didn't I?

Is that going to be your testimony, sir?

THE WITNESS: Honestly, Your Honor --

THE COURT: It's all we've got is honesty.

THE WITNESS: That's all I'm going to give you.

I interviewed or listened to interviews on 50 different people. I'm going to testify that -- that Elliott Williams said he had a broken neck. I'm going to testify to he laid in his cell for ten and a half hours untreated.

I'm going to say that Williams rammed his head into a cell door. I'm going to say that people seen him standing when he wasn't, the medical staff. I'm going to say that he -- that they didn't know where he was paralyzed and couldn't figure it out.

I'm going to say that he's continued to complain since when he entered his cell until he left, I don't know, four, five, six, seven days later, whatever it is. That he continued to claim that he had a broken neck.

I'm going to -- I'm going to testify to nurses putting in

wrong orders into the -- or lying about the -- what they put into his medical chart.

THE COURT: Let me pause you right there, because most of what you just talked about are things other people told you, that's not medical opinion. You're just relaying what was told to you and then you draw your opinion from that.

The issue about nurses putting wrong orders or lying in the medical records, where did that come from?

THE WITNESS: From the medical records themselves. From --

THE COURT: So did you compare what they were saying to what was in the medical records?

THE WITNESS: Your Honor, after -- I'm going to testify to not just in this document that if there's any other things that's given to me, I'm going to testify to -- for like one of the documents that I have reviewed is Ms. Young's document. She's dead and then a nurse comes in and puts in she's, you know, her blood pressure is this and she's oriented and she's alive just a few minutes later. So...

THE COURT: How did you figure -- how did you come to the conclusion that a nurse put in evidence into a medical record after Ms. Young had passed?

THE WITNESS: It's wrote in her medical charts. I read it.

THE COURT: Okay.

THE WITNESS: It's the medical charts that I've reviewed multiple times and --

MR. SMOLEN: I mean, just a lot of what we do is comparing what the video shots because he pulls the video off the jail systems. He reviews the video. So for example with Mr. Williams, nurses were reporting that Mr. Williams was up walking around the cell using the restroom.

The video evidence that Mr. McKelvey pulled from his investigation shows that Mr. Williams laid in his cell and didn't get up to ever use the restroom.

It's not an opinion, it's a factual finding based on his investigation. I'm not asking him, and was that medically appropriate for them to do that, I'm saying, what did you find. He's going to say, I reviewed medical shift logs that said he was up using the bathroom. We watched surveillance video from the entire time he was in cell number 1, this man never stood up. That's a factual finding.

THE COURT: Here's what rule 701 states, quote, "If a witness is not testifying as an expert, or qualified and presented as an expert" --

MR. SMOLEN: No, he's not.

THE COURT: -- "testimony in the form of an opinion is limited to one that is, A, rationally based on a witness's perception." Sounds like what he's relying upon, statements he's read, information that he's provided by these witnesses,

video that he's reviewed.

"B, helpful to clearly understanding the witness's testimony or to determining a fact in issue." Well, that's certainly met.

"And not based on scientific, technical or other specialized knowledge within the scope of 702." Reading medical records about what somebody said when they said them is not medical, it is comparing what a fact is to another fact and drawing a conclusion. So overruled.

MR. SMOLEN: Thank you, Your Honor.

THE COURT: We're at 4:30. Let's go for another half hour, unless you need a break. Does anyone need a quick break? Okay. Let's bring back the jury. Thank you.

(THE FOLLOWING PROCEEDINGS WERE HAD IN OPEN COURT, WITHIN THE PRESENCE AND HEARING OF THE JURY:)

THE COURT: Thank you. You can be seated. Do you need the last question read back to you or can you do it from memory, or do you want it off your notes? Pick one.

THE WITNESS: I would prefer it read back, please.

THE COURT: If you want to go with a different question.

MR. SMOLEN: I think I can break it down a little simpler.

Q. (BY MR. SMOLEN) Mr. McKelvey, I want to focus just with respect to -- I want to set this up for the jury. When were

you investigating Mr. Williams' death? What was the timeframe that you were investigating that?

A. I believe he -- he died October -- if I can look at my notes, I can tell you exactly when he died and when I finished the report.

Q. Look at your report, your executive summary, not your full hundred-page report but your executive summary, okay, the very top paragraph. Does that refresh your memory as to when this encounter with Mr. Williams started?

A. Yes.

Q. When was it?

A. October 21st of 2011.

Q. Okay. And then I want you to look at the bottom of your report on that executive summary, okay. And can you tell the jury how long Mr. Williams was in the Tulsa County Jail before he was found deceased?

A. Yes.

Q. Okay. Take a minute, refresh your memory, and let the jury know essentially when he was booked into the jail and then the date when he was found deceased.

A. He was booked into the jail on October 21st and died October 27th.

Q. Okay. And did you investigate that entire time period that he was housed in the jail?

A. Yes.

Q. And I want to kind of take you step by step into what you found on each of those days; okay? I think that might be easier. Are you ready?

A. Yes, sir, that would be great.

Q. Okay. Based on just your executive summary, okay. And if you can do it from your memory, great, but if you can't, feel free to refresh your memory.

THE COURT: Let us know if you're looking at the document; okay?

THE WITNESS: Yes, sir.

Q. (BY MR. SMOLEN) What did you find -- or what did you document in your executive summary that you found as it pertained to Mr. Williams when he was first booked into the jail?

A. Off memory, when he was first booked into the jail, I believe there was a confrontation with the Owasso Police Department in the prebook area where he was physically taken to the ground.

And then once he came into the booking area of the jail, he did become agitated and he was ultimately put in a holding cell there in the prebook area. He ran his -- he ran into the cell door or the window and from there I never seen him walk under his own power again.

Q. Let me -- I want to take one step back, okay. The holding cell you described to the jury, was it a video-monitored

holding cell?
A. No.
Q. Okay. Based on your investigation -- and I want to talk about just specifically this non-video-monitored holding cell, did you make findings as it pertained to what medical staff did on Mr. Williams' first day after he had rammed his head when he was in a non-video-monitored holding cell?
A. I don't remember specifically.
Q. Okay. Take a look at your report on your executive summary, okay. On the third paragraph I want you to read it to yourself and I want you to see if that refreshes your memory specifically about what you found as it pertained to just the initial holding cell.
A. What I found was jail staff and medical staff both went into the cell. And how I know this is there's a video camera outside of the holding cell that captures the foyer area of -- I believe it's three separate holding cells. And I watched, via the camera, jail staff and medical staff entering the cell and then coming back out. And upon review of that video and reading other documents, Williams was on the ground complaining that he had broken his neck.
Q. Did you find that Williams reported to CHC nursing staff while in the holding cell that he had broken his neck?
A. Yes.
Q. And can you tell the jury what nurse he specifically told,

or nurses for CHC, were specifically told by Mr. Williams that he had broke his neck?
A. At the holding cell time frame?
Q. Yes, sir, I want to just focus on the holding cell.
A. I believe it was Nurse Hughes.
Q. Okay. And after -- or did you find that after Nurse Hughes had been informed by Mr. Williams that he had broken his neck, what did you find that Nurse Hughes did?
A. Nurse Hughes rubbed his neck and rubbed his upper back area. They set him up in the cell, meaning they, the nurse and the detention staff, set him up in the cell and she massaged his neck.
Q. Okay. Based on your investigation at the time that Mr. Williams indicated to Nurse Hughes that he had broke his neck, was he ever viewed walking again in the jail?
A. I -- I have reports that he had been walking, yes, but from the video that I have, no, he never walked.
Q. Okay. And we're going to get into that in a little bit of detail later, but I want you to listen to the question, okay. Based on your investigation into the death of Elliott Williams, after he had reported to CHC Nurse Hughes that he had broken his neck, was there any evidence that you found, credible evidence that you found, that Mr. Williams ever walked again?
A. No.

Q. Okay. I want you to look at your larger report if you would. And again, I don't want to you read from this, but I want to see if this helps refresh your memory a little bit more about what you found pertaining specifically to Nurse Hughes; okay? If you would, look at the Bates page -- look at Bates page 3064. Excuse me, I'm sorry, 3141.

A. I'm there.

Q. 3064, paragraphs 13 to 15, read those to yourself, okay.

A. I'm sorry, did you say 3141?

Q. 3064, I apologize.

THE COURT: He did say 31.

MR. SMOLEN: I did and I misspoke.

Q. (BY MR. SMOLEN) And I'm sorry, Mr. McKelvey. 3064.

A. Okay. I'm there.

Q. I want you to just, to yourself, read paragraph 15 and see if you learned any more information through your investigation pertaining to Nurse Hughes.

A. Okay.

Q. Does that refresh your memory specifically about your findings as it pertained to Nurse Hughes while Mr. Williams was in the non-video-monitored holding cell?

A. Yes.

Q. Can you tell the jury what you learned from your investigation particularly pertaining to CHC Nurse Hughes during this timeframe?

A. Just -- it's an awful big paragraph, so I'm going to do my best to summarize it. He complained about his neck. She rolled him on his side like he asked. He was able to move his head. He moved his head some and I believe he moved his hands some so she claimed or thought that that -- he's not -- he's claiming he can't move, he can't get up, but he's able to move his head and his hands and so he's obviously -- he's not all there or the information is not all there, so she's basically disregarding it.

Q. Did you determine, based on your investigation, that Nurse Hughes thought Mr. Williams was faking a broken neck?

A. Yes.

Q. Do you recall from your investigation after Mr. Williams reported that he had a broken neck how long he was left by himself in holding cell number 10 in the booking area?

A. I'll need to look at my notes.

Q. If you will, go ahead and take a look at your notes. I'll have you look at 3141 just to speed this up, Mr. McKelvey.

A. Thank you.

Q. Second paragraph, sir.

A. Mr. Williams was left in the holding cell for ten and a half hours.

Q. And based on your investigation, did any medical staff for CHC do anything to help Mr. Williams for that ten-hour period of time that he was in holding cell 10 unable to walk?

A. They didn't.
Q. Okay. Were you able to determine how many times -- what happened next, Mr. McKelvey, after Mr. Williams was laying in the cell for ten hours unable to walk? Can you tell the jury what you found happened next?
A. Yes. The next shift that came on, the supervisor made a determination that after talking with the jail nurse or the booking nurse that if Williams wasn't able to get up, they would just call a medical emergency, that way they could get a gurney to take him to medical.
Q. Okay. And did you review videotape from that during your investigation?
A. Yes.
Q. Was Mr. Williams, in fact, lifted onto a gurney and removed from the non-video-monitored holding cell?
A. Yes.
Q. After Mr. Williams was removed from the non -- let me ask you this, while he was lifted onto the gurney, was CHC staff present?
A. Yes.
Q. Did you find anything that indicated that CHC staff did anything to protect his neck from further injury?
A. They did not protect his neck.
Q. Tell the jury, if you can, what you recall happening next to Mr. Williams.

A. He was put on a gurney and taken to the medical unit of the jail where he was assessed by a nurse and a number of medical people there and jail detention staff.

Q. Do you recall from memory what CHC nurses specifically interacted with Mr. Williams after the medical emergency had been called on his first day in the jail?

A. Not specifically, no.

Q. All right. Take a look at your report, okay, at 3067 at paragraph 28.

I apologize, Mr. McKelvey, it's 3067, paragraph 30.

A. Okay. I'm sorry, what was your question?

Q. My question was: After Mr. Williams was removed from the holding cell, placed on the gurney, brought down to medical for this medical emergency, okay, did you find anything else out about what the nursing staff believed was happening with Mr. Williams?

A. Yes. Mr. Williams was faking -- faking that he couldn't walk, that he couldn't move.

Q. At the time that nursing staff made the determination early on in his stay at the Tulsa County Jail that Mr. Williams was faking, to your knowledge, based on your investigation, did any medical staff, prior to making the determination that he was faking, do any kind of physical assessment on Mr. Williams?

A. Their -- you're going to have to direct me.

Q. Okay.
A. I'm doing my best not to show any disrespect to the courts and -- because I need to be directed where to look in my report because I can't remember.
Q. Okay. That's fine. We'll get through it. Did you learn that when Mr. Williams was brought to medical that soon thereafter he was taken to the shower stalls?
A. Yes.
Q. Okay. And what did you learn happened when Mr. Williams was brought to the shower stalls on his first day in the jail?
A. What I -- what I recall is he was told to get off the gurney by staff. I remember a nurse --
THE COURT: Pause right there. When you say "staff," we need to be careful between jail staff and nursing/CHC staff. So make sure you're careful on that; okay.
THE WITNESS: Yes, sir. Thank you.
THE COURT: Thank you very much.
A. He was told to get up by jail staff to get off the gurney, and he was also told to get up by the nursing staff to get off the gurney. He said he couldn't. One of the nurses -- and I would have to look in my report, but one of the nurses said "get up, I know you're faking."
He didn't so -- and he had defecated on himself and so

they took him -- when I say "they," the jail staff took him to the jail or the cell in medical that has a shower in it and they took him off the gurney, stripped him of his clothes and put him in the shower and turned the shower on and closed and locked the door and he was told to wash himself.

Q. (BY MR. SMOLEN) I want you to look at page 3141 in your report in the fourth paragraph and see if that refreshes your memory as to which CHC nurse, now in the shower of the medical unit, claimed Mr. Williams was faking a broken neck.

A. Okay. It was RN Nurse Chappell.

Q. Okay. So now we've got a second nurse for CHC hearing reports from Mr. Williams that he can't get up, that his neck is broken, that he can't get up, and the second nurse also thinks he's faking?

A. That's correct.

Q. Okay. Do you recall from your investigation how long after Mr. Williams -- let me ask you this: Did you find out how Mr. Williams got off the gurney if he couldn't walk?

A. Yes.

Q. What did you find out?

A. What I remember is the jail staff tilted the gurney in a manner for him to slide off of the gurney into the shower.

Q. And during him being dumped off the gurney, was Mr. Williams ever able to stand or walk?

A. No.

Q. After Mr. Williams was dumped -- well, let me ask you this: When Mr. Williams was dumped off the gurney, were CHC nurses present?

A. Yes.

Q. Did anyone take any protective action to protect his neck?

A. No.

Q. After Mr. Williams was dumped off the gurney into the shower in the medical unit, how long did he lay there?

A. If memory serves me correctly, he laid there roughly an hour.

Q. Based on your investigation, okay, based on your findings, was Mr. Williams himself even capable of washing the feces off of his body while he laid in the cell?

A. No. And let me clarify that previous answer. He -- Mr. Williams was in this shower for roughly two hours. He was slid off the gurney into the shower, positioned in a way where the shower head would hit his lower half of the body, and then roughly an hour had passed, detention staff came back into the shower, rolled him over and positioned him in a manner where the shower head would hit him in the buttocks.

Q. Did your investigation find that during this first, let's say, 12 hours of interaction at the jail that Mr. Williams was repeatedly telling medical staff that he was paralyzed?

A. Yes.

Q. What happened -- if you recall, after Mr. Williams laid in the shower for two hours, what happened next?
A. Mr. Williams was removed from the shower, this time placed on a gurney and taken to a -- a -- another cell where the nurses and the detention staff was there and he was -- he was placed in another cell and placed on suicide watch.
Q. Okay. Based on your investigation, did Mr. Williams ever indicate that he was suicidal?
A. No, he did not.
Q. Okay. And when Mr. Williams was placed in this cell, was the cell in the medical unit?
A. Yes.
Q. Do you recall what the cell number was?
A. I'm going to say medical cell 26.
Q. You're correct, Mr. McKelvey. Based on your understanding of the jail video camera system, was cell 26 a video-monitored cell?
A. No.
Q. When Mr. Williams was housed in cell 26, was he clothed?
A. No.
Q. Okay. Can you describe to the jury, based on your investigation, what you found him to be dressed as, dressed in?
A. He was not dressed. He was placed on a suicide blanket, which a suicide blanket is a -- the bottom half or the one

side of the suicide blanket is real thick, heavily sewn, minor padding and then there's a -- I wouldn't call it a sheet, it was more of a heavy blanket that's heavily sewn so they can cover up, but he had no clothes.

Q. Okay. And he's essentially in there naked on a wool suicide blanket; is that right?

A. Yes.

Q. Okay. And based on your investigation, what did you find the next interaction to be that Mr. Williams had with CHC medical staff?

A. I remember that being a weekend and I remember jail staff and medical staff entering the cell. And I remember an inmate actually entering the cell and all at the -- it was all at the same time and Williams was complaining that he was thirsty and so the inmate worker brought him a glass of water and the detention staff helped him drink the water or set him up in a manner to pour the water in his mouth.

Q. Okay. I appreciate you trying to do it from memory, okay, but I know you wrote a hundred pages or so, but I want to have you look at it and just read those to yourself because my question is specifically pertaining to nursing staff.

Look at 3069 to 3070, paragraphs 46, if you would, sir. And just read it to yourself and let me know if that refreshes your memory about what your investigative findings were.

A. What paragraph?

Q. Paragraph 46. It should be between 3069 and 3070.
A. Okay.
Q. Does that refresh your memory?
A. Yes. It was reported that the nurse said he looked fine, there's nothing wrong with him. The person that was being interviewed could not give a name of the nurse but gave a description of the nurse to be a black female.
Q. Did you know who the nurse was that was described?
A. I would have to look, but I believe it's Nurse Chappell.
Q. Okay. Let me ask you this: Did you find based on your investigation at the time Mr. Williams was housed in cell 26 if any nursing staff took any vitals?
A. I would have to look.
Q. Okay. Take a look, if you would. Again, it should be the same paragraph of that report you were just looking at. Paragraph 46.

THE COURT: And while the witness is looking at that, how much more testimony do you have of this witness regarding to Mr. Williams and the witness's investigation of Mr. Williams?

MR. SMOLEN: Probably another -- I would say 45 minutes, Your Honor, just because we've just -- the second day or first day still.

THE COURT: I understand. Is there a good breaking point? I know you're walking through the witness sort of day

by day with Mr. Williams. Are we getting to a good point -- breaking point?

MR. SMOLEN: Yeah, this is a great spot if you'd -- I'll stay all night.

THE COURT: Well, I think they've got other things they've got to do, but why don't we finish with the question on whether or not vital signs were taken of Mr. Williams by any nursing staff. I think that was the last question.

MR. SMOLEN: Yeah, it was.

Q. (BY MR. SMOLEN) And, Mr. McKelvey, I'm talking about vital signs taken while he's now in cell 26.

A. The report tells me that no vital signs was taken.

Q. Okay.

MR. SMOLEN: Your Honor, if you would like us to break now.

THE COURT: Okay. We'll take a break. All right. Don't talk about the case, keep an open mind, don't investigate anything. I don't know -- do they get fed at all? Do they get donuts? No.

DEPUTY COURT CLERK: Well you do now, yes.

THE COURT: Put it on my bill. Put it on the Northern District of Illinois' bill. We'll bring you in here at 9:00 to get started; okay. All right. Thanks.

(THE FOLLOWING PROCEEDINGS WERE HAD IN OPEN COURT, OUT OF THE PRESENCE AND HEARING OF THE JURY:)

THE COURT: Somebody I think left their notes.

All right. Have a seat.

Based upon last week, I think it was when we were here, it sounded like we're going to have an issue about Dr. Adusei's status, whether employee or agent or an independent contractor.

I don't want to have that discussion in the middle of his testimony or at the beginning of his testimony. What would be extremely helpful to allow me to do my job to make a determination under 801(d)2D, as in dog, would be his agreement with CHC.

So if anybody has that, that would be helpful for me to read tonight so that I can get ahead of the curve of this case and tackle issues outside of the jury's presence. So if anybody has his agreement with CHC, I think that would go a long way as well as any testimony we might need. But the agreement itself would be a good starting point, and that's what the law says I should look at.

MR. SMOLEN: Your Honor, can I excuse Mr. McKelvey unless you're going to need him again until the morning?

THE COURT: You can be excused. Thank you. Be here a little before 9:00.

MR. SMOLEN: Thank you.

THE COURT: Sorry, I forgot he was there.

MR. SNIDER: Your Honor, Defendant's --

THE COURT: I'm sorry, your voice came from here, but you're standing there. Sorry.

MR. SNIDER: Defendant's Exhibit 56 would be Dr. Adusei's agreement.

THE COURT: 56, okay. Hold on a second.

MS. WINTER: And, Judge, if it's not in your binder, that may have been one we withdrew after his dismissal. So if you look there and it's not, I'd be happy to get you a hard copy at some point in the future.

THE COURT: 55. My exhibits go from 55 to 60.

MS. WINTER: I think that was one we withdrew after his dismissal.

THE COURT: Which makes sense. That's understandable.

MR. SNIDER: I do have a hard copy.

THE COURT: I don't want to take your only copy. We can make a copy. Okay. That would be great.

DEPUTY COURT CLERK: Do you need a copy? You do not?

MR. SNIDER: I've got more paper.

THE COURT: I'll take it. Thank you very much, Counsel. Thank you.

DEPUTY COURT CLERK: Where does this go in with it?

THE COURT: That's a signature page probably. Thank you. Okay. I'll take a look at this tonight so at least I

have the knowledge of this document on that issue. *Crews v. Farmers Insurance*, not a bad case, kind of helpful, 42 F.4th 1205.

MR. CHAPMAN: Could you repeat that, Your Honor?

THE COURT: Sure. *Crews v. Farmers Insurance Exchange*, 42 F.4th 1205. And you've got, oh, some ancient law from Oklahoma, *Ellis and Lewis v. Trimble*, 57 -- I always found it interesting that Oklahoma is in the Pacific reporters, but it is. So 57 P.2d 244 and 246. That's Oklahoma 1936. Still good law as far as I could tell, we could tell.

Broach Company, Inc., v. City of Corona, 2004 U.S. District Lexis 32094 lays out some factors. So I know what the law is, I need to know what the facts are, okay, so we can talk about that before we get Dr. Adusei on the witness stand.

So that's what I wanted to cover before we close tonight. Anything from the Plaintiff's side?

MR. SMOLEN: Nothing from the Plaintiff's side. Thank you, Your Honor.

THE COURT: How about from the Defense?

MR. SNIDER: Nothing, Your Honor.

THE COURT: Okay. Be here no later than 8:45 so we can get the jury in here at 9:00 promptly. Okay. Thank you.

(PROCEEDINGS CONCLUDED)

REPORTER'S CERTIFICATION

I CERTIFY THAT THE FOREGOING IS A TRUE AND CORRECT TRANSCRIPT OF THE PROCEEDINGS IN THE ABOVE-ENTITLED MATTER.

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